Protocol/Guideline Relating To InterNASC transfers - Older Persons

AIM

The aim of this procedure is to describe and guide the process to be followed for the management of InterNASC transfers for clients funded through Older Persons NASC's.

All clients are entitled to support to ensure continuity of supports as they relocate from one part of the country to another. This can only be achieved where there is consistency in processes.

SCOPE

This protocol relates to Older Persons NASC's across NZ

PROCESS

Each NASC will have their own internal process, but at a minimum should ensure the following is covered.

Outgoing transfers

1. Confirm all relevant details with client, family, and receiving facility (if known)
2. Complete the interNASC transfer form making sure to include:
   - Name, date of birth and current address
   - New address/facility requested – if known otherwise tick the box for information requested
   - If under 65 ensure that the funding stream they are under is highlighted on form
3. Attach the following documents
   - Current assessment (this would generally be expected to be an appropriate interRAI assessment (in line with National "What assessment" Guide), and include assessment, assessment comments, client summary (or outcome scores) and care plan
     NB: check if the receiving NASC has access to your local "office" - if so, there is no need to send the assessment, but it should still meet criteria below, and any other documents not attached to Momentum still need to be sent.

   If client is moving to community
     - Is it under 1 year old with good detail of current needs?
     - Are currently provided supports documented?
     - Does it include correct contact details of the family/NOK

   If client is moving to residential care
     - Is it a RAI-HC (or LTCF), reflecting the current level of care needs of client ie rest home, dementia, hospital or psychogeriatric?
     - Is the assessment appropriate for the level of care being requested?
     - Is there an EPOA – particularly important for dementia or psychogeriatric placements (most facilities require this evidence before agreeing to a geriatric or psychogeriatric placement)? Provide relevant documents if invoked.
     - Does it include correct contact details of the family/NOK
   - Relevant MoH or DHB sign-offs:
     - If under LTS-CHC funding will need a copy of the acceptance and also the submission forms

    - If under alternate DHB funding may need a copy of the acceptance (this may need to be discussed with receiving NASC as funding streams will not be the same in all NASC's)
    - Sign off for level of Care – Dementia, Hospital or Psychogeriatric
4. Check whether client needs a residential care subsidy (or subsidy documents – send if required) or already receiving a subsidy, and put on the transfer form (if known)
5. Email (preferred method) or fax all documents to relevant service.
6. Consider phone call to service to ensure document has arrived etc. Especially important if there are any "tricky" aspects (eg if no facility known, client already moved etc)
7. Document when application sent etc
8. When acceptance received, liaise with client, family, facility etc as necessary
9. Notify LP/SC to transfer Momentum/interRAI file to new NASC (in some area the NASC may be able to do this directly).

Incoming transfers

1. Check
    - Name, date of birth and current address and the new address/facility requested
    - If under 65 check disability and what funding stream they are under
    - If the dominant need is not age related contact the NASC to advise to send to All of Life / Disability NASC
2. Check accompanying documentation
   For community to community transfers:
    - Is the assessment under 1 year old with good detail of current needs?
    - Does the assessment reflect the current needs, and supports being provided to meet those needs?

   For transfers to residential care
    - Does the assessment reflect the current needs of client ie rest home, dementia, hospital or psychogeriatic?
    - Is the assessment appropriate for the level of care being requested?
    - Do they meet national / local access criteria?
    - Check for any sign offs – dementia, hospital or psychogeriatric (these are required as per receiving NASC requirements, whatever the originating DHB's policy is)
    - Is there an EPOA listed – particularly important for dementia or psychogeriatric? If invoked, are all documents provided.
    - If under LTC-CHC funding a copy of the acceptance and also the submission forms is required
3. Contact the NASC if more information is required or to request an updated assessment
4. If InterNASC form requests information on facilities and options, contact the person listed as contact person to give them details of facilities and vacancies in the region.
5. If for residential care:
    - Check the local bed status as to whether you are able to accept client
    - Ring the facility and check if they are aware of this client and whether they have a bed available. Send the assessment to them if they request this. The manager of the facility will advise if they will accept the client or not and what date they can accept the client.
    - Check whether needs a residential care subsidy application, or already receiving a subsidy
6. Discuss with Service Manager (or delegated team member) who either accepts or declines inter-NASC.
7. Email (preferred method) or fax InterNASC form back to originating NASC.
8. Phone contact person to advise of acceptance/decline of transfer.
9. If being placed in residential care, check and confirm with the contact person whether to send a subsidy application form and who to send it to (it is expected that this would only be required if this were the first residential placement for the client, and had not been provided in their originating NASC).

10. If client is going into their own home ensure that home based supports are arranged to start on required date.
11. Once date of transfer is confirmed, notify interRAI system clinician and request transfer of file on Momentum on the date of transfer (in some area the NASC may be able to do this directly).
12. Ensure service / support allocation is entered into local management system for submission to Sector Services
13. Once date of transfer is confirmed, notify interRAI system clinician and request transfer of file on Momentum on the date of transfer.

OVER-ARCHING PRINCIPLES

A response is requested from the receiving NASC within 2 working days – in urgent cases discussion should be held between the 2 NASCs to negotiate a shorter timeframe. It is acknowledged that in some circumstances a response cannot be made within the 2 day timeframe, this should be discussed between the 2 NASC's.

Acceptance of client for a specific level of support is dependant on meeting the criteria for services or support in the receiving area.

In line with national Ministry of Health requirements, the relevant interRAI assessment would be the expected assessment to be provided.

It would be expected that the receiving NASC would review the assessment outcomes when receiving the request, and discuss any differences in service provision in the receiving area with originating NASC, client or family, before the transfer is confirmed / occurs.

Generally acceptance of clients with community supports will be less problematic and able to be accepted without much delay, while acceptance of residential placements will be determined by local pressure on available beds, and other local priorities.

INTER-NASC TRANSFER REQUEST

To (NASC): **Fax No:**
e-mail address:

From: **at (NASC**
e-mail address:

Re: **NHI:** **DOB:**

Current Address	**New Address**
Contact No:	Contact number:

Reason for Transfer:

Proposed date of Transfer:

Please find Attached:
☐ interRAI assessment ☐ Sign-off or funding approvals ☐ Specialist Reports
or
☐ interRAI assessment available for viewing in our office Other:_____

Current Support Package:
☐ Home Supports ☐ Residential Care ☐ Supported Living

Personal Care- Hrs: Household Management-Hrs: Day Care-Days:
Respite - Days: Carer Support: Other:

Requested Support Package:

☐ Home Support ☐ Residential Care ☐ Supported Living

Residential Care Requested:
Level of Care: Requested Date of Transfer:

☐ Requires information regarding residential care options in new location

To be completed by receiving NASC

Acceptance

Or: Acceptance pending (is further information required, requested bed not available at present etc):

_____

_____

Or: **Client unable to be accepted**:

Name: Signature:
Date: NASC:

_____